M. SCREENING - EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to all recipients from birth through age 20 who are patients of the primary care center, or who are accepted by the center as patients for EPSDT, following referral from another source (i.e. Department for Social Insurance, Department for Social Services, Local Health Department Outreach Unit, local schools, etc.).

1. The early and periodic screening services shall be under the direction of a duly-licensed physician, nurse practitioner, or registered professional nurse currently licensed by the state of Kentucky who shall be responsible for assuring that the requirements of participation are met and that the procedures established by the Program are carried out. Paramedical staff performing screening examinations and tests shall be trained and their services limited to their area of competence and in accordance with the professional practice acts governing the health disciplines.

2. The screening package shall include, but not be limited to, the following basic screening services for eligible recipients as appropriate for age and health history and in accordance with acceptable standards for preventive health care in children.

   a. Health and developmental history
   b. Unclothed physical examination
   c. Developmental assessment
   d. Vision and hearing testing

e. Assessment of immunization status and updating immunization
f. Assessment of nutritional status
g. Laboratory procedures

(1) Hemoglobin or hematocrit
(2) Sickle cell*
(3) Urinalysis
(4) Tuberculin skin test
(5) Lead*
(6) Serology for syphilis and/or*
(7) Culture for gonorrhea

*When Medically Indicated

3. Screening providers will be reimbursed for the screening services outlined above, and as appropriate for age and health history, rendered to eligible Title XIX clients as soon as they are declared eligible for Medicaid, and at the following ages:

02-04 weeks	16-19 months	07-08 years
02-03 months	23-25 months	09-10 years
05-06 months	3 years	11-12 years
09-10 months	4 years	13-14 years
12-15 months	5 years	15-16 years
	6 years	17 through 20 years

4. The clinic shall maintain a medical record for each recipient screened with all entries kept current, dated, and signed. The record shall include, but is not limited to, the following:

   a. Patient history
   b. Physical assessment findings
   c. Growth and development records
   d. Disposition of patient
   e. Name of referral source (name of physician, dentist, etc.)
   f. Record of immunization
   g. Copy of agency reporting forms
   h. Copy of referral form

5. All center records of recipients are to be completed promptly and are to be systematically filed and retained for 5 years.

   a. The center shall have policies to provide for the systematic retention and safekeeping of recipients' medical records for the required period of time in the event that the clinic discontinues operation.

b. If the recipient moves to an area outside the center's service area, written permission of the parent or guardian shall be obtained so that a copy of the recipient's medical records can, and shall be, transferred to the clinic providing service in that area.

c. Screening providers receiving requests for release of EPSDT findings to Boards of Education and/or Head Start Programs are directed to:

(1) Establish an agreement with the appropriate school superintendent and/or head start official to safeguard confidential information. A copy must be retained in the center's files. Individualized agreements to safeguard confidential information are not required but the agreement would cover all persons within the category living in the school district.

(2) Obtain written authorization for the release of EPSDT findings to school superintendents and/or head start official from the parent and/or legal guardian.

(3) Prior to releasing EPSDT findings, individual screening records must be marked "confidential information."

6. The center shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined herein.

The area utilized during the testing period of the EPSDT exam shall provide adequate privacy and a minimum of interference to assure maximum accuracy from the test.

7. The center shall make available for review and audit by authorized representatives of the KMAP at all reasonable times the medical, administrative, and financial records pertaining to services rendered to Program recipients.

   Representatives of the Program will conduct (1) surveys to determine compliance with Federal, State and local regulations, and (2) fiscal audits to determine cost of care.

8. The KMAP recognizes that cases of suspected child abuse and neglect may be uncovered in regular Early and Periodic Screening Program examinations. If such cases are discovered, an oral report shall be made immediately by telephone or otherwise to a representative of the local Department for Social Services office. Within 48 hours a report in writing shall be made to the local Department for Social Services office for use in investigation and appropriate action to protect the child involved.

   To facilitate reporting of suspected child abuse and neglect cases, legislation effecting the reporting of child abuse, (KRS 199.335) is printed on the reverse of Cabinet for Human Resources Child Abuse Reporting Forms (DSS-115). These forms may be secured from the local Department for Social Services office. A copy of this form is included in the Appendix.

9. Basic Services

The following tests and assessment procedures may be used in evaluating the health status of the Program recipient. The procedures outlined are suggested testing procedures; however, APPROVED equivalent procedures may be used to obtain the desired results. The "Standards for Preventive Health Care in Children" is to be used as a reference manual.

a. Medical History

A medical history will be obtained from the parent or guardian by qualified personnel and retained in the recipient's medical record. A consent form shall be signed by the parent, guardian, or responsible person authorizing the provider to perform the basic screening tests, update the immunizations, and to share pertinent information with any state agency providing service or supervising services to the recipient.

The health service provider's professional staff (R.N., A.R.N.P., or M.D.) is responsible for obtaining the medical history. If this responsibility has been delegated by the professional to a trained paraprofessional, the professional must review the findings with the parent and/or legal guardian at the time of the physical assessment examination.

The parent and/or legal guardian has authority to give written consent for the EPSDT service. The Department for Social Services will in some instances be the legal guardian for an eligible Medicaid recipient and therefore will have authority to give the required written consent for EPSDT services. It should be noted, however that the Department for Social Services only has this authority for those cases committed by the courts to their care, i.e. foster care children.

b. Procedures and Tests

The following procedures and tests shall be performed in accordance with acceptable standards for preventive health care in children, as appropriate for age and health history.

(1) All recipients of screening services shall have their height and weight recorded and their growth percentile measured using a standard chart. Development shall be assessed by health history, physical findings, appraisal of the significant milestones of the maturation process, and utilization of standard growth and development charts.

Standard growth charts constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control may be secured by request from the Division of Medical Assistance.

(2) A blood pressure shall be taken on eligible recipients over 35 months of age and/or on all recipients of screening services when indicated.

(3) A routine throat inspection shall be done on each recipient by the examining physician, nurse, or nurse practitioner.

(4) A routine dental inspection shall be carried out. Some of the children, 3 years of age and above, may have accepted the dental component of EPSDT and been referred at intake by outreach staff to the dentist for diagnosis and treatment.

(5) All eligible recipients are to be checked for obvious physical defects such as hernia, orthopedic, skin, eye, etc. If any abnormality is detected, diagnosis and treatment or a referral shall be initiated.

(6) A complete or dip stick urinalysis (blood, sugar, ketone bodies, and protein) shall be done on each recipient as appropriate for age and health history. Bacteriuria screening shall be done for the at risk groups.

Supplies and forms for Bacteriuria screening can be obtained by writing:

Kidney Screening Program
Department for Health Services
Division of Preventive Services
275 East Main Street
Frankfort, Kentucky 40621

(7) Visual screening shall be carried out using the appropriate Snellen Chart and/or equivalent tool. Screening results in recipients too young to utilize the standard equipment may be obtained by other means such as observation, object identification, etc.

(8) All recipients should be checked for evidence of ear disease such as obvious infection, foreign bodies, wax impacted canal, drainage, or other abnormalities. At the age of 47 months and up an audiometric evaluation should be performed.

(9) A hematocrit or hemoglobin shall be done on each eligible recipient as appropriate for age and health history.

(10) When medically indicated, all eligible recipients who are at high risk for sickle cell anemia shall be offered screening for sickle cell anemia either on-site or by referral.

(11) Tuberculin Skin Tests shall be performed on eligible recipients who are at risk for developing tuberculosis.

NOTE: Since local and district health departments have the resources and are mandated to control tuberculosis, KMAP service providers should work with their local health departments to insure that all necessary medical, nursing and epidemiological follow-ups are provided to KMAP service recipients found to have infection or disease.

(12) An assessment of immunizations should be made and immunizations updated if necessary. Program payment does not include the cost of vaccines. The administration of the vaccine is included in the charge for the screening service.

NOTE: Information regarding immunizations and vaccines may be obtained by contacting:

The Department for Health Services Division of Local Health Communicable Disease and Prevention Section 275 East Main Street Frankfort, Kentucky 40621

(13) Serology for syphillis and/or a culture for gonorrhea shall be done when the history and nursing assessment indicate the necessity.

(14) Routine testing for lead poisoning shall not be required by the Program; however, in those cases where the physical symptoms or environmental conditions indicate possible lead poisoning, a referral should be made to the physician or to the appropriate medical service for follow-up. If referral is made for lead poisoning, the block 14 on the MAP-7 should be completed.

Referrals:

At the end of the screening process abnormalities noted should be discussed in terms understandable and meaningful to the recipient, parent and/or guardian, and arrangements initiated or referrals made for diagnosis and treatment.

It is expected that the primary care centers will provide most necessary diagnosis and treatment services, reducing the need for referrals to other providers, and establishing continuity in the patient's care and treatment.

All referrals, either within the Center or to other outside providers, shall follow the procedures listed for setting up diagnosis and treatment appointments.

a. Clients capable of and preferring to make their own appointments.

(1) Appropriate assistance is given the client by the screening provider.

(2) Note the screening finding on the Referral Form CH-115 and give two (2) copies of the completed referral form to the client for presentation to the referral resources.

b. Clients unable to follow through with making appointments for diagnosis and treatment.

(1) The client's choice of referral resources is honored and appointments are made for diagnosis and treatment by the screening provider.

(2) Note the screening finding on the Referral Form CH-115 and forward two (2) copies of the completed referral form to the referral resource.

c. The screening provider is to:

(1) Refer EPSDT participants to Title V services when appropriate (See Directory of Title V Services)

(2) Assist clients with abnormality(ies) for which treatment is not covered by the State Title XIX plan in securing needed diagnosis and treatment services at little or no cost to the client.

e. The KMAP requires your help as a provider of screening services in the identification and referral of clients who may be eligible for Women, Infants and Children (WIC) Supplemental Food Program.

The WIC Program is designed to provide specific nutritional foods to pregnant women; breast-feeding women, up to one (1) year postpartum; or women to six (6) months postpartum, plus infants and children under five (5) years of age, who reside in an approved area and are determined to be at nutritional risk by a health professional.

In order for the local WIC Project to be made aware of these children, you are asked to utilize the Referral Form (CH-115) for any recipient screened whom you identify as potentially eligible for WIC benefits. The completed CH-115 form should then be forwarded to your local WIC Project.

The WIC Supplemental Food Program nutritional risk criteria and a list of local WIC Projects may be secured from the Department for Medicaid Services.

SECTION IV - SERVICES COVERED

Procedural Coding

Following EPSDT services, the invoice form (MAP-7) is to be completed in accordance with the instructions in Section VI - Completion of the Invoice Form, with special attention directed to the services and tests listed in blocks #11 and #12. The following coding should be entered in each box for each service and test listed:

CODE	ASSESSMENT
A	Normal
B	Abnormal Referred
C	Abnormal under treatment

If referrals have been made, designate in blocks #14 and #15.

All EPSDT examinations will use procedure code Y6000.

SECTION IV - SERVICES COVERED

N. Health Education Services

Definition

These services must provide as a minimum appropriate personnel to present, on request, information on general health care to local school systems, civic organizations and other concerned local groups. Services are to include distribution of written material on pertinent health subjects.

Health Education counseling rendered eligible recipients on an individual basis is a cost-allowed service. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

O. Nutritional Services

These services must be provided by a professional nutritionist on the staff of the Primary Care Center, and must include as a minimum individual counseling relating to nutritional problems or nutritional education. Group nutritional services may also be provided.

Nutritional counseling rendered eligible recipients on an individual basis is a cost-allowed service. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

P. Social Services Counseling

These services must be provided by a licensed, graduate, or certified social worker on the staff of the Primary Care Center. As a minimum, the services must include information and referral services. Intensive counseling is to be limited to crisis situations and health related problems. Individuals with other identified counseling needs are to be referred to appropriate social service agencies.

Individual social services counseling rendered eligible recipients is a cost-allowed service. Counseling services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

Q. Outreach Services

These services must be provided as a package structured to identify health care needs in the service area.

Outreach services made as part of an established plan of care for the patient and/or family, shall be documented in the patient's records as to the nature and purpose of the visit. Services may be reported on the year-end cost report as a cost of the center's total cost, but cannot be billed on the MAP-7.

SECTION IV - SERVICES COVERED

R. Holding/Observation Accommodations

Utilization of holding/observation accommodations maintained by the center will be covered, within the limitations outlined below:

1. Utilization by an eligible recipient will be considered a covered benefit for not more than 24 hours.

2. Decisions to hold patients shall be the responsibility of a physician(s) on the medical staff of the center.

3. A licensed nurse shall be on duty at the center when a patient is held in center accommodations beyond regular scheduled hours.

4. A duly-licensed physician shall be on call at all times during which a patient is held beyond the regular scheduled hours of the center.

5. All procedures relating to the retention of and rendition of services to patients held in center accommodations shall be set forth in the center's patient care policies.

Procedure Code: Z9084 - Holding/Observation

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. Method of Reimbursement

Primary care services are reimbursed in accordance with a cost reimbursement system, involving a cost-based, all-inclusive rate per visit at the time of service with a year-end settlement to adjust payments to allowable costs. The details of this system are explained in the Primary Care Reimbursement Manual as follows:

Part I General Policies and Procedures
Part II Principles of Reimbursement
Part III Annual Cost Report Instructions
Part IV Annual Cost Report

A billable service, one that will generate a payment of the established rate per visit, is defined as a visit or encounter which includes a face-to-face contact and a professional medical service by either a physician, physician assistant (if licensed), nurse practitioner, dentist, or optometrist on the staff of the Primary Care Center. However, if a center elects to provide home health services as an identifiable package which meets the requirements specified in the Primary Care Program regulations, any staff member providing services meeting these requirements who is eligible to bill under the existing home health element of the Medical Assistance Program may also bill under the Primary Care Program. A billable service is limited to a single professional visit on a given day regardless of the number or variety of services received during such visit (i.e., only one Medicaid bill per day can be generated). However, this does not preclude two or more billable services (i.e., Medicaid bills) from being generated if 1) the patient is seen at different locations (i.e., outstation and main center) on the same day or 2) has a second visit at the same location which resulted from a different circumstance, purpose, or need.

B. Medicare, Title XVIII Coverage

In accordance with the Primary Care Services Principles of Reimbursement, any KMAP responsibility for a recipient's Medicare (Title XVIII) deductible and coinsurance payments for covered services will be reflected on the invoice form (MAP-7) and allocated during the year end cost settlement, (See Reimbursement Manual, Part III, cost report instructions, section 108, page 8.05.)

The Primary Care Center shall bill the appropriate Medicare (Title XVIII) fiscal intermediary, prior to billing. If billing EDS Medicare on the HCFA-1500 billing form, the primary care center must not check the "Medicaid" block on the HCFA-1500 form nor enter the Medical Assistance Identification Number and must choose one of the following: 1) Require recipient to sign the HCFA-1500 claim form for Medicare purposes; or 2) Obtain a blanket assignment from the recipient which will permit the provider to enter the words "Blanket Assignment on File" in the signature block of the HCFA-1500. The MAP-7 form shall then be completed as for any recipient, with the amount received from Medicare reported in block 29. Program payment for the services reflected on the invoice will be the center's interim rate (CAC) less the amount received from Medicare.

C. Reimbursement in Relation to Other Third Party Coverage (Excluding Medicare)

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services must actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, he/she should determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

2. Identification of Third Party Resources

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions: If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer; if the recipient is a minor, ask about insurance the MOTHER, FATHER, or GUARDIAN may carry on the recipient; in cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder; for people over 65 or disabled, seek a MEDICARE HIC number; ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc., EXAMINE THE RECIPIENT'S MONTHLY ELIGIBILITY CARD FOR AN INSURANCE INDICATOR AND IF AN INDICATOR IS PRESENT, QUESTION THE RECIPIENT FURTHER REGARDING OTHER INSURANCE.

3. Private Insurance

If the patient has third party resources, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not made payment within 120 days of the date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance

claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

4. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers must accept Medicaid payment as payment in full.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a Third Party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider must pursue payment with this third party resource before billing Medicaid again.

5. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider should pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as, the names of attorneys, other involved parties and/or the recipient's employer to the claim when submitting to EDS for Medicaid payment.

D. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General

The Health Insurance Claim Form (HCFA-1500) (12/90) shall be used to bill for all primary care services rendered eligible Kentucky Medicaid Program recipients. A claim or invoice is to be completed to reflect all services rendered a recipient on a given date, even when the services do not constitute a "billable service." A definition of billable service may be found in Section V - Reimbursement, and in the Reimbursement Manual, PART I, Section 103, page 3.01.

The original of the two part invoice set shall be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall be retained by the provider as a record of claim submitted.

Invoices shall be mailed to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602

B. Completion of the Health Insurance Claim Form, HCFA-1500 (12/90)

An example of a Health Insurance Claim Form, HCFA-1500 (12/90) is shown in the appendix. Instructions for the proper completion of this form are presented below.

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. There can be no Medicaid payment for services rendered to an ineligible person.

The age of the patient will also be reflected on the Identification Card. This shall be noted, specifically in cases where the patient requires services that are limited to recipients UNDER the age of 21.

SECTION VI - COMPLETION OF INVOICE FORM

HCFA-1500 (12/90) forms may be obtained from:

U.S. Goverment Printing Office
Superintendent of Documents
Washington, D.C. 20402

Telelphone: 1-800-621-8335

BLOCK NO.	ITEM NAME AND DESCRIPTION
2	PATIENT'S NAME Enter the recipient's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card.
9A	OTHER INSURED'S POLICY OR GROUP NUMBER: Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.
10B,C	ACCIDENT: Check the appropriate block if treatment rendered was necessitated by some form of accident.
11	INSURED'S POLICY GROUP OR FECA NUMBER Complete if the recipient has any kind of private heatlh insurance that has made a payment, other than Medicare.
11C	INSURANCE PLAN NAME OR PROGRAM NAME Enter the name of the insurer and the policy number.
19	INSURED'S GROUP NUMBER Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.

SECTION VI - COMPLETION OF INVOICE FORM

21 DIAGNOSIS CODE

Enter the appropriate ICD-9-CM diagnosis codes. Does not apply to pharmacy and non-emergency dental services.

23 PRIOR AUTHORIZATION NUMBER

If the service provided requires prior authorization, enter the prior authorization number assigned by EDS.

24A DATE OF SERVICE

Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, April 16, 1992 would be entered as 04-16-92.

24B PLACE OF SERVICE

Enter the appropriate place of service code from the list on the back of the claim form identifying where the service was provided.

24D PROCEDURE CODE

Enter the procedure code which identifies the service or supply rendered to the recipient. For pharmacy claims, enter the twelve (12) digit NDC number.

24E DIAGNOSIS CODE INDICATOR

Transfer "1", "2" or "3" from the field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

SECTION VI - COMPLETION OF INVOICE FORM

24F PROCEDURE CHARGE

Enter your usual and customary charge for the service rendered.

24G DAYS OR UNITS

Enter the number of times this procedure was provided for the recipient on this date of service. For pharmacy services, enter the drug quantity of each prescription billed.

24H EPSDT Family Plan

Enter a "Y" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment Examination.

24K RESERVED FOR LOCAL USE

When billing pharmacy services, enter the prescription number. When billing dental services, enter the tooth number(s). Enter the vaccine dose for vaccinations. Enter the EPSDT referral codes, if applicable, for EPSDT.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first seven or fewer digits. This number will appear on the Remittance Statement as the invoice number.

28 TOTAL CHARGE

Enter the total of the individual procedure charges listed in column 24F.

SECTION VI - COMPLETION OF INVOICE FORM

29 AMOUNT PAID

Enter the amount received by any other private insurance, DO NOT INCLUDE Medicare. If no health insurance payment amount, leave blank.

30 BALANCE DUE

Enter the amount received from Medicare.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider (not a fascimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit individual Medicaid provider number.

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* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
*Claims for covered services must be received by EDS within twelve*
*(12) months from the date of service. Claims with service dates *
*more than twelve (12) months old can be considered for processing*
*only with appropriate documentation such as one or more of the   *
*following: Remittance Statements no more than 12 months of age  *
*which verify timely filing, backdated MAID cards, Social Security*
*documents, correspondence describing extenuating circumstances,  *
*Action Sheets, Return to Provider Letters, Medicare Explanation  *
*of Medicare Benefits, etc.                                       *
* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
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PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

NEW FORM

APPENDIX VIII OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER — FOR PROGRAM IN ITEM 1

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS — Single | Married | Other — Employed | Full-Time Student | Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# — GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500
FORM OP 050191

TRANSMITTAL # 19

SECTION VI - COMPLETION OF INVOICE FORM

26 No entry required.

27 TOTAL CLAIM CHARGE:

Enter the total of lines 1 - 10.

28 HEALTH INSURANCE AMOUNT:

Enter the total amount (if any) received from the patient's health insurance for services billed.

29 AMOUNT FROM MEDICARE:

Enter the total amount received from Medicare for services billed. Attach a copy of the Medicare Explanation of Benefits to claim.

30 PROVIDER NAME:

Enter the name and address of the Primary Care Center performing the services being billed.

31 PROVIDER NUMBER:

Enter the eight-digit Medicaid provider number assigned to the provider listed in block 30.

32 AUTHORIZED SIGNATURE:

The actual signature of the provider or authorized representative is entered here.

33 COUNTY:

No entry required.

34 AREA:

No entry required.

SECTION VI - COMPLETION OF INVOICE FORM

35 INVOICE DATE:

Enter the month, day, and year that the invoice was signed and submitted to Medical Assistance (i.e., November 15, 1988 would be entered 11 15 88).

36 DATE OF SERVICE:

Enter the month, day and year (numeric equivalent as block 35) the services were provided. One date of service per claim.

37 CHARGE DISPOSITION:

No entry required.

38 INVOICE NUMBER:

No entry required.

39 No entry required.

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* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
*Claims for covered services must be received by EDS within twelve*
*(12) months from the date of service. Claims with service dates *
*more than twelve (12) months old can be considered for processing*
*only with appropriate documentation such as one or more of the   *
*following: Remittance Statements no more than 12 months of age  *
*which verify timely filing, backdated MAID cards, Social Security*
*documents, correspondence describing extenuating circumstances,  *
*Action Sheets, Return to Provider Letters, Medicare Explanation  *
*of Medicare Benefits, etc.                                       *
* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
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VII. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION VII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix XIII-A. This section lists all those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR PRIMARY CARE SERVICES

ITEM	DEFINITION
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS.
CLAIM SVC DATE	The earliest and latest dates of services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.

AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
LINE NO.	The number of the line on the claim being printed
POS	Place of service code depicting the location of the rendered service
PROC	Procedure code in the line item
RX NO.	The prescription number used by the pharmacist to identify this prescription
DRUG CODE	The drug code number of the prescription that was dispensed
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix XIII-B.

All items printed have been previously defined in the description of the paid claims section of the Remittance Statement.

D. Section III - Claim in Process

The third section of the Remittance Statement (Appendix XIII-C) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Peturned Claims

The fourth section of the Remittance Statements (Appendix XIII-D) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/ DENIED	The total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.
AMOUNT PAID	The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.
WITHHELD AMOUNT	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies).

NET PAY AMOUNT — The dollar amount that appears on the check.

CREDIT AMOUNT — The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount).

NET 1099 AMOUNT — The total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix XIII-E).

SECTION VIII - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-372-2921 (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare/Medicaid Crossover Claims	-	12 months from date of service NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	-	12 months from date of service NOTE: If the other insurance company has not responded within 120 days of date of service, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	-	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-372-2921 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION VIII - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Description
1	Enter your 8-digit Medicaid Provider Number. If you are a KMAP certified clinic enter your 8-digit clinic number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

Field Number	Description
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Communications Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

PRIMARY CARE SERVICES
APPENDIX

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

DENTAL SERVICES

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

FAMILY PLANNING SERVICES

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis. Coverage for home health services is not limited by age.

HOSPITAL SERVICES

INPATIENT SERVICES

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

OUTPATIENT SERVICES

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medical Assistance Program (KMAP) participating independent laboratories includes KMAP reimbursable procedures for which the laboratory is certified by the Department of Health and Human Services to perform.

LONG-TERM CARE FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

INTERMEDIATE CARE FACILITY SERVICES

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.*

*Need for the intermediate level of care and the ICF/MR/DD level of care must be certified by a PRO.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

MENTAL HOSPITAL SERVICES

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

NURSE MIDWIFE SERVICES

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHYSICIAN SERVICES (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)
Smear for Bacteria, stained
Throat Cultures (Screening)
Red Blood Count
Hemoglobin
White Blood Count
Differential Count
Bleeding Time
Electrolytes
Glucose Tolerance
Skin Tests for:
- Histoplasmosis
- Tuberculosis
- Coccidioidomycosis
- Mumps
- Brucella

Complete Blood Count
Hematocrit
Prothrombin Time
Sedimentation Rate
Glucose (Blood)
Blood Urea Nitrogen (BUN)
Uric Acid
Thyroid Profile
Platelet count
Urine Analysis
Creatinine

Bone Marrow spear and/or cell block; aspiration only
Smear; interpretation only
Aspiration; staining and interpretation
Aspiration and staining only
Bone Marrow needle biopsy
Staining and interpretation
Interpretation only
Fine needle aspiration with or without preparation of smear; superficial tissue
Deep tissue with radiological guidance
Evaluation of fine needle aspirate with or without preparation of smears
Duodenal intubation and aspiration: single specimen
Multiple specimens
Gastric intubation and aspiration: diagnostic
Nasal smears for eospinophils
Sputum, obtaining specimen, aerosol induced technique

PODIATRY SERVICES

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

SCREENING SERVICES

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

TRANSPORTATION SERVICES

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are arranged for and provided by home health agencies.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.